

REQUIREMENTS AND INSTRUCTIONS - PHYSICIAN ASSISTANT

Access this form via website at: www.state.hi.us/dcca/pvl

APPLICANTS ARE SUBJECT TO REQUIREMENTS IN EFFECT AT THE TIME OF FILING.

APPLICATION FOR LICENSURE

Fill in all spaces and answer all questions in dark ink. Sign the application.

- **Failure to provide all the requested information will delay the processing of your application.**

FEE

Attach appropriate fee payable to: **COMMERCE & CONSUMER AFFAIRS.**

If you will be licensed during this period, pay:

February 1, even-numbered year through January 31, odd-numbered year \$150
(Application fee - \$20*, License fee - \$25, Compliance Resolution Fund - \$90,
½ renewal for second year of two-year license period - \$15)

If you will be licensed during this period, pay:

February 1, odd-numbered year through January 31, even-numbered year \$ 90
(Application fee - \$20*, License fee - \$25, Compliance Resolution Fund - \$45)

Note: One of the numerous legal requirements that you must meet in order for your new license to issue is the payment of fees as set forth in this application. You may be sent a license certificate before the check you sent us for your required fees clears your bank. If your check is returned to us unpaid, you will have failed to pay the required licensing fee and your license will not be valid, and you **may not** do business under that license. Also, a \$15.00 service fee will be charged for checks which are returned by the bank.

If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.

**The application fee is not refundable.*

FEDERATION DISCIPLINE REPORT

Send the attached form, "Federation Discipline Report - Physician Assistant" to the Federation. The Federation will send the report directly to the BME.

EDUCATION

ATTACH a photocopy of your certificate from the institution where you completed a training program for physician assistant.

EXAM

ATTACH a photocopy of your certificate from NCCPA for passing the National Certifying Exam.

ATTACH a photocopy of current NCCPA certificate. Certificate shall include the expiration date.

FOR EXAM INFORMATION CONTACT:

NCCPA
157 Technology Pky Ste 800
Norcross, GA 30092-2913

Phone: (770) 734-4500
www.nccpa.net

VERIFICATION

ATTACH verification form signed by you and your supervising physician licensed in Hawaii.

FILING DEADLINE

Submit all required items (application, fees and supporting documents) at least 2 weeks prior to employment starting date.

Mail all required items to:

PHYSICIAN ASSISTANT
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96801

or

Deliver to office location at:

1010 Richards St., 1st Floor
Honolulu, HI 96813
Phone: (808) 586-3000

**TEMPORARY
LICENSE**

A temporary license to practice as a physician assistant may be granted to an applicant who has graduated from an approved training program within 12 months of the date of application and has never taken a national certifying examination approved by the board. The applicant shall file a complete application with the board and pay all the required fees. If the applicant fails to apply for, or to take the first examination scheduled following the issuance of the temporary license, fails to pass the examination, or fails to receive licensure, all privileges shall automatically cease. Call the licensing branch at (808) 586-3000 for more information on this type of license.

**INACTIVE
STATUS**

If an applicant is not under the supervision of a licensed physician, the license will be placed on an inactive status.

**REACTIVATION
STATUS**

To reactivate, submit reactivation fee of \$40 and Verification – Supervising Physician (AMD-03).

**LAWS AND RULES
PUBLICATION**

To obtain a copy of the laws and rules relating to physician assistant, send \$2.00 payable to COMMERCE & CONSUMER AFFAIRS to: *Cashier, Commerce & Consumer Affairs, P. O. Box 541, Honolulu, HI 96809* and **ask for the MEDICAL LAWS AND RULES**. Chapter 436B, Hawaii Revised Statutes, the Professional and Vocational Licensing Law may be purchased separately for 75¢. (Price subject to change without notice.)

The rules are posted on our website at: www.state.hi.us/dcca/pvl, then click the specific board/program. The laws will be posted during the fall of 2001.

**ABANDONMENT OF
APPLICATION**

You must submit all required documents and information within two years from the last date documents or information were requested or it will be considered abandoned and the Board may destroy it.

BIENNIAL RENEWAL

To maintain licensure by the board, a renewal fee is due by January 31 of each even-numbered year. Your certificate from NCCPA must also be current to maintain licensure

Application for Licensure - PHYSICIAN ASSISTANT

Name (First, Middle)		(Last)	
Residence Address (include apt. no., city, state & zip code)			
Mailing Address (if different from above)			
Other names used			
Social Security No.	Phone No. (days)	OPTIONAL	Sex: M F Birthdate:

FOR BOARD USE ONLY

CHECKOUT:		Approved
[] \$90 or \$15		Denied
[] PA cert		Initials/Date:
[] NCCPA cert		
[] Supervisor Verification		
[] Fed. Disc. Report		
Date issued	Cert. No.	

Circle or underline answers:

- 1) Are you at least 18 years of age? YES NO
- 2) Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the United States? YES NO
- 3) Have you graduated from a physician assistants training program approved and accredited by the Committee on Allied Health Education and Accreditations of the American Medical Association (AMA)? YES NO
- 4a) Have you passed the National Certifying Exam developed by the NCCPA? YES NO
- b) When does your certification expire (mo/day/yr)?
- 5) Have you ever been convicted of a crime relating to your practice as a physician assistant which has not been annulled or expunged? YES NO
(If "yes," give jurisdiction, action taken, dates and reasons for action on a separate sheet.)
- 6a) Has any medical-related license you hold or ever held ever been suspended, revoked or otherwise subject to disciplinary action? YES NO
(If "yes," give jurisdiction, action taken, dates and reasons for action on a separate sheet.)
- b) Is any disciplinary action presently pending against you? YES NO
(If "yes," give jurisdiction, dates and nature on a separate sheet.)

EDUCATION	Name of Program/College	Location	Major and Degree Earned	Dates (mo/yr)	
				Entry	Graduated
	Physician Assistant Program and Name of College				
	Other College/University				
EXPERIENCE	Name and Address of Employer	Duties	Name of Supervisor	Dates (mo/yr)	
				From	To

Affidavit of Applicant:

I hereby certify that the answers and statements provided on this application and the documents attached are true and correct. I understand that misrepresentation is grounds for refusal or subsequent revocation of licensure (*Section 710-1017, Hawaii Revised Statutes*).

Date: _____

Signature of Applicant: _____

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

App	323	\$20
Lic	312	\$25
CRF	C13	\$45/\$90
1/2 Renewal	300	\$15
Service Fee	BCF	\$15

BOARD OF MEDICAL EXAMINERS

TO: Physician Assistant
FROM: Board of Medical Examiners
SUBJECT: Statement of Supervising Physician

Enclosed for your information is a copy of Subchapter 6, Certifying Physician Assistants, of Chapter 16-85, Hawaii Administrative Rules, of the Board of Medical Examiners. The subchapter requires that supervising physicians shall submit a statement that they will direct and exercise supervision over any subordinate physician assistant in accordance with Subchapter 6.

To facilitate this requirement, a form (enclosed) has been developed that can be used for this purpose. After you have completed and signed your portion, please provide a copy of this form to each of your supervising physicians for completion and submission to the address below.

Physician Assistant
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

Any questions regarding this requirement should be directed to the Executive Officer of the Board of Medical Examiners at (808) 586-2708.

**HAWAII ADMINISTRATIVE RULES
CHAPTER 85
MEDICAL EXAMINERS**

SUBCHAPTER 6

CERTIFYING PHYSICIAN ASSISTANTS

§16-85-44 Authority and purpose. The purpose of this subchapter is to implement section 453-5.3, HRS, which delegates to the board of medical examiners the responsibility to adopt rules regarding standards of medical education and training governing physician assistants, such standards to equal but not be limited by existing national education and training standards, and the degree of supervision required by a supervising physician. [Eff 6/30/81; am and comp 7/27/87; comp 10/28/89; comp 8/25/90; comp 12/22/97] (Auth: HRS §§453-5.1, 453-5.3) (Imp: HRS §453-5.3)

§16-85-44.5 Definition. As used in this subchapter:

"Physician assistant" means an individual who has been certified by the board to practice medicine with physician supervision. A physician assistant may perform those duties and responsibilities delegated by the physician assistant's supervising physician.

"Supervising physician" means a physician or group of physicians or an osteopathic physician and surgeon licensed to practice medicine and surgery in this State who accepts the responsibility for the supervision of services rendered by physician assistants. The supervising physician shall direct and exercise supervision at all times.

"Supervision" means overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. Supervision shall be continuous but shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place the services are rendered. [Eff and comp 7/27/87; am and comp 10/28/89; comp 8/25/90; am and comp 12/22/97] (Auth: HRS §§453-5.1, 453-5.3) (Imp: HRS §453-5.3)

§16-85-45 Education. All physician assistant educational programs approved and accredited by the American Medical Association's Committee on Allied Health Education and Accreditations, or its successor agency shall be approved by the board of medical examiners. [Eff 6/30/81; comp 7/27/87; comp 10/28/89; comp 8/25/90; am and comp 12/22/97] (Auth: HRS §§453-5.1, 453-5.3) (Imp: HRS §453-5.3)

§16-85-46 Certification application. (a) An application for certification shall be made under oath on a form to be provided by the board. The form may require the applicant to provide:

- (1) The appropriate fees including the application fee which shall not be refunded;
- (2) The applicant's full name;
- (3) Evidence of graduation from a board approved school or training program;
- (4) Evidence of passage of the national certification examination developed by the National Commission on Certification of Physician's Assistants (NCCPA);
- (5) Evidence of current NCCPA certification;

- (6) Information regarding any conviction of any crime which has not been annulled or expunged;
- (7) A completed Federation Discipline Report from the Federation of State Medical Boards;
- (8) If applicable, evidence of any certifications held or once held in other jurisdictions indicating the status of the certification and documenting any disciplinary action;
- (9) Any other information the board may require to investigate the applicant's qualifications for certification;
- (10) A statement signed by the licensed physician or group of physicians, as the case may be, stating that the physician or group of physicians will direct and supervise the physician assistant and that the physician assistant will be considered the agent of the physician or group of physicians; and
- (11) The name of the employer.

(b) An application for a temporary certificate shall be made under oath on a form to be provided by the board. The form shall require the applicant to provide verification from the NCCPA that the applicant is scheduled to take the next scheduled examination and items listed in subsection (a) above with the exception of items (4) and (5). Graduation from a board approved school or training program shall have occurred within twelve months of the date of application.

(c) It shall be the applicant's responsibility to furnish any information and documentation requested by the board. In the event of any change of information provided, the applicant shall notify the board of any change within thirty days of any change.

(d) Every application and all references shall be signed by the applicant or the person attesting to the applicant's education, experience, employment, and reputation. [Eff 6/30/81; am and comp 7/27/87; comp 10/28/89; comp 8/25/90; am and comp 12/22/97] (Auth: HRS §§453-5.1, 453-5.3) (Imp: HRS §453-5.3)

§16-85-47 Certification document and identification. (a) Upon approval of the application, the board shall issue a physician assistant certificate which recognizes that the applicant is competent to perform under appropriate supervision those duties and functions specifically delegated to the applicant by a physician or group of physicians. The certificate is subject to biennial renewal, and the appropriate fees shall be paid to maintain current certification.

(b) A physician assistant who meets all requirements for certification but who is not employed as a physician assistant shall be certified on an inactive status.

(c) The physician assistants shall introduce themselves as physician assistants to all patients for whom the physician assistants may provide services. [Eff 6/30/81; am and comp 7/27/87; comp 10/28/89; comp 8/25/90; am and comp 12/22/97] (Auth: HRS §§453-5.1, 453-5.3) (Imp: HRS §453-5.3)

§16-85-48 Renewal. To be eligible for renewal of physician assistant certification, the physician assistant shall maintain national certification by the NCCPA. [Eff 6/30/81; am and comp 7/27/87; comp 10/28/89; comp 8/25/90; comp 12/22/97] (Auth: HRS §§453-5.1, 453-5.3) (Imp: HRS §453-5.3)

§16-85-49 Degree of supervision. (a) The supervising physician shall:

- (1) Possess a current unrestricted Hawaii license to practice medicine and surgery that is in good standing with the board;
- (2) Submit a statement that the supervising physician will direct and exercise supervision over any subordinate physician assistant in accordance with this subchapter and recognizes that the supervising physician retains full professional and legal responsibility for the performance of the physician assistant and the care and treatment of the patient;
- (3) Permit the physician assistant to be utilized in any setting authorized by the supervising physician including, but not limited to, clinics, hospitals, ambulatory centers, patient homes, nursing homes, other lodging, and other institutional settings;
- (4) Provide adequate means for direct communication between the physician assistant and the supervising physician; provided that where the physical presence of the supervising physician is not required, the direct communication may occur through the use of technology which may include but is not limited to, two way radio, telephone, fax machine, modem, or other telecommunication device;
- (5) Personally review the records of each patient seen by the physician assistant within seven working days;
- (6) Designate an alternate supervising physician in the physician's absence;
- (7) Supervise no more than two physician assistants at any one time; and
- (8) Be authorized to allow the physician assistant to prescribe, dispense, and administer medications and medical devices to the extent delegated by the supervising physician and subject to the following requirements:
 - (A) Prescribing and dispensing of medications may include Schedule III through V and all legend medications. No physician assistant may prescribe Schedule II medications;
 - (B) A physician assistant who has been delegated the authority to prescribe Schedule III through V medications shall register with the Drug Enforcement Administration (DEA);
 - (C) Each prescription written by a physician assistant shall include the name, address, and phone number of the supervising physician and physician assistant. The printed name of the supervising physician shall be on one side of the form and the printed name of the physician assistant shall be on the other side. A physician assistant who has been delegated the authority to prescribe shall sign the prescription next to the printed name of the physician assistant;
 - (D) A physician assistant employed or extended privileges by a hospital or extended care facility may, if allowed under the bylaws, rules, and regulations of the hospital or extended care facility, write orders for medications Schedule II through V, for inpatients under the care of the supervising physician;
 - (E) The board of medical examiners shall notify the pharmacy board in writing, at least annually or more frequently if required by changes, of each physician assistant authorized to prescribe;

§16-85-49

- (F) A physician assistant may request, receive, and sign for professional samples and may distribute professional samples to patients; and
- (G) All dispensing activities shall comply with appropriate federal and state regulations.

(b) The supervising physician or physicians and the physician assistant shall notify the board within ten days of severance of supervision or employment of the physician assistant. [Eff 6/30/81; am and comp 7/27/87; comp 10/28/89; comp 8/25/90; am and comp 12/22/97] (Auth: HRS §§453-5.1, 453-5.3) (Imp: HRS §§453-5.1, 453-5.3, 460-1)

§16-85-49.1 Scope of practice. (a) A physician assistant shall be considered the agents of the physician assistant's supervising physician in the performance of all practice-related activities as established in writing by the employer.

(b) Medical services rendered by the physician assistants may include, but are not limited to:

- (1) Obtaining patient histories and performing physical examinations;
- (2) Ordering, interpreting, or performing diagnostic and therapeutic procedures;
- (3) Formulating a diagnosis;
- (4) Developing and implementing a treatment plan;
- (5) Monitoring the effectiveness of therapeutic interventions;
- (6) Assisting at surgery;
- (7) Offering counseling and education to meet patient needs; and
- (8) Making appropriate referrals.

(c) Physician assistants may not advertise in any manner without the name or names of the supervising physician or physicians, as the case may be, or in any manner which implies that the physician assistant is an independent practitioner. [Eff and comp 12/22/97] (Auth: HRS §§453-5.1, 453-5.3) (Imp: HRS §§453-5.1, 453-5.3)

§16-85-50 Automatic inactivation for failing to be under supervision; restoration. (a) Certification shall be automatically inactivated if the physician assistant is no longer supervised by a physician or group of physicians.

(b) Certification may be reactivated provided the applicant pays all applicable fees, including renewal fees as applicable, and submits:

- (1) A statement signed by the licensed physician or group of physicians, as the case may be, who will direct and supervise the physician assistant;
- (2) The name of the hospital or clinic employing the physician assistant if appropriate; and
- (3) Evidence of current certification by the NCCPA.

(c) The board may, when reviewing any application for reactivation, deny or reject the application in accordance with section 16-85-107. [Eff and comp 12/22/97] (Auth: HRS §§453-5.1) (Imp: HRS §§453-5.1, 453-5.3)

§16-85-51 Revocation, limitation, suspension, or denial of certification. Any certification to practice as a physician assistant may be revoked, limited, or suspended by the board at any time in accordance with section 16-85-120 or may be denied for any one or more acts listed in chapter 453, HRS or this chapter. [Eff and comp 7/27/87; comp 10/28/89; comp 8/25/90; am and comp 12/22/97] (Auth: HRS §§453-5.1, 453-5.3) (Imp: HRS §453-5.3)

§16-85-52 Repealed. [R 12/22/97]

SUBCHAPTER 7

CERTIFYING EMERGENCY MEDICAL SERVICE PERSONNEL

§16-85-53 Authority and purpose. The purpose of this subchapter is to implement section 453-33, HRS, which delegates to the board the authority to adopt rules regarding certification of individuals as qualified in emergency medical services. [Eff 12/17/82; am and comp 7/27/87; comp 10/28/89; comp 8/25/90; am and comp 12/22/97] (Auth: HRS §453-33) (Imp: HRS §453-33)

§16-85-53.5 Definitions. As used in this subchapter:

"Advanced life support" shall be defined as provided in chapter 321, HRS, and its subsequent amendments which are incorporated into and made a part of this subchapter.

VERIFICATION – SUPERVISING PHYSICIAN

Access this form via website at: www.state.hi.us/dcca/pvl

Check one:

- ☐ New license
☐ Notification of changes to my record
☐ Reactivation*

BOARD USE

- ☐ AMD current?
☐ MD current?

PHYSICIAN'S ASSISTANT	Name of Physician Assistant (<i>LAST, First, Middle</i>)	Hawaii License No. AMD-	Registration No. or Scheduled Test Date
	Mailing Address		Is this a new address? YES NO

SUPERVISING PHYSICIAN	Check and complete one of the paragraphs below, then sign and complete information at the bottom.												
	<p><input type="checkbox"/> I, _____, M.D., hereby state that I will direct and exercise supervision over the above-named physician assistant in accordance with Subchapter 6 of Chapter 16-85, Hawaii Administrative Rules, of the State of Hawaii Board of Medical Examiners. I recognize that I retain full professional and legal responsibility for the performance of the above-named physician assistant and the care and treatment of the patient.</p> <p>Effective Date of Direction and Supervision _____</p>												
	<p><input type="checkbox"/> I, _____, M.D., hereby state that I am no longer directing the activities of the above-named physician assistant as defined under Subchapter 6 of Chapter 16-85, Hawaii Administrative Rules, of the State of Hawaii Board of Medical Examiners.</p> <p>Termination Date of Direction and Supervision _____</p>												
	<table><tr><td>Signature of Supervising Physician _____</td><td>Date _____</td><td>Signature of Physician Assistant _____</td><td>Date _____</td></tr><tr><td colspan="2">Print Name of Physician _____</td><td colspan="2"></td></tr><tr><td colspan="2">License No. Of Physician _____ MD-</td><td colspan="2"></td></tr></table>		Signature of Supervising Physician _____	Date _____	Signature of Physician Assistant _____	Date _____	Print Name of Physician _____				License No. Of Physician _____ MD-		
Signature of Supervising Physician _____	Date _____	Signature of Physician Assistant _____	Date _____										
Print Name of Physician _____													
License No. Of Physician _____ MD-													

*If you are reactivating your license – attach \$40 payable to: Commerce & Consumer Affairs

Mail to: *Physician Assistant
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96801* or

Deliver to office location:
*1010 Richards St., 1st Floor
Honolulu, HI 96813*

Questions? Call (808) 586-3000 or (808) 586-2708

FEDERATION DISCIPLINE REPORT - PHYSICIAN ASSISTANT

TO THE APPLICANT: All applicants for license are required to provide completion of this report by the Federation of State Medical Boards.

Complete the APPLICANT section and applicant must mail this form to:

*Federation of State Medical Boards
400 Fuller Wiser Rd., Ste 300
Euless, TX 76039-3855
Phone: (817) 868-4000*

APPLICANT	LAST NAME (CAPITAL LETTERS), First, Middle	Social Security No	Birthdate
	Medical School of Graduation & Branch Location	Date of Graduation	
	<p>I authorize the Federation of State Medical Boards to indicate on this form if there is any previous or pending disciplinary action against my license in any state.</p> <p>Date _____</p> <p style="text-align: right;">_____ Signature of Applicant</p>		

FEDERATION	<u>TO THE FEDERATION:</u> Please indicate below if there is any previous or pending disciplinary action against any license of the above-named individual.
	<div>Signature _____</div> <div>Title _____</div> <div>Date _____</div>

PLEASE RETURN THIS FORM DIRECTLY TO THE HAWAII BOARD OF MEDICAL EXAMINERS AT THE ADDRESS BELOW:

*Board of Medical Examiners
DCCA, PVL Licensing Branch
P. O. Box 3469
Honolulu, HI 96801*

LICENSING BRANCH
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

To receive confirmation of your license, fill in your name and mailing address in the block below on the "Notice of Licensure" form. This confirmation will take about 3 weeks to process. The license card will take about 6 weeks to process.

NOTICE OF LICENSURE

Professional and Vocational Licensing Division
Department of Commerce and Consumer Affairs
State of Hawaii

This is authorization to act as a **PHYSICIAN ASSISTANT** until such time that a license is processed.

THIS AUTHORIZATION IS VALID ONLY WHEN SIGNED BY THE EXECUTIVE OFFICER OF THE BOARD.

Print Name and Complete Mailing Address in Block Below:

LICENSE NO. AMD -

EFFECTIVE DATE _____

EXPIRATION DATE January 31, _____

Executive Officer